FINAL REPORT

BATH COUNTY (Hot Springs)

Bath Community Hospital
Critical Access Hospital (CAH)

Virginia Department of Health
Office of Minority Health and Public Health Policy
Medicare Rural Hospital Flexibility Program (FLEX)
Agreement through the Virginia Rural Health Resource Center

Submitted by:

Congregational Health ReSource, LLC
Rev. Andrea C. Lomboy, Founder & President

CONGREGATIONAL HEALTH RESOURCE, LLC
Wholeness through health & faith-based solutions

December 31, 2009

EXECUTIVE SUMMARY

Over one half of Virginia's population attends church.[1] By leveraging the 7,000+ congregations (*excluding African American Congregations) of the Commonwealth as a force multiplier, the reach of public health can be much more extensive and effective. As one global mission group notes, the church is the "only community-based organization that is found in virtually every community in this country. It is able to reach people of all ages, races, and economic backgrounds and it can strongly influence people's values and personal life choices. Because the church is generally more integrated into the life of individuals and communities than our modern medical establishment, it can better enable people to assume responsibility for their own health."[2]

Yet churches are clearly underutilized as community health partners and lack health expertise and resources. By uniting the best practices of public health with faith-based principles and organizations, we can begin to close the gaps as health inequities are identified and their root causes are addressed at the core of communities. Congregational health (see Appendix A) brings together the best practices of public health and congregational-based principles by emphasizing wellness, wholeness, prevention, and education. When considering public health, it cannot be ignored.

Through collaborations and partnerships with other congregations and local, state, and national organizations, the church can provide quality health information and core health-related services to its members. However, a more formal process needs to be developed and implemented in local congregations. The Virginia Department of Health (VDH) has an opportunity to maximize the capacity of public health and can take steps in closing the gap by supporting future efforts.

Toward this goal, the Congregational Health ReSource, LLC (CHR) was commissioned by the Virginia Department of Health, Office of Minority Health (VDH OMHPHP) to perform congregational health assessments using federal Medicare Rural Hospital Flexibility Program (FLEX) funds. The assessments were designed to fulfill the shared mission of each partner: to address the health needs of congregations by using public health ideas and efforts.

In this pilot program, CHR was tasked with developing five congregational health assessments (clergy, civic, medical, government, and education) (see Appendix B), surveying Bath County, Virginia, and providing recommendations to VDH OMHPHP and the community based on the findings. This pilot study is among the first faith-based efforts by the Commonwealth at a community-wide level focusing on a rural community.

Survey Findings

Bath County has a total population just over 4,500 people who live within a 540 square mile radius of mountainous terrain. The most populous group is Caucasian[3] (~92%) with the remaining groups comprising less than 7% of the total population. The average income is just over $42,000[4], which is much lower than the average for the Commonwealth. The result of this has lead to 8.5% of its residents living below the state poverty level. Seventy-four percent of have graduated with a high school diploma; however, only 11% of those have obtained a Bachelor's degree or higher[5]. Of those congregations completing surveys for this pilot, most are Evangelical or Mainline Protestants and have been in existence for more than 50 years, have an average size congregation of less than 200 members (with 1 exception, membership was > 400), and predominantly female (~62.5%) and primarily Caucasian (~97%) (only one congregation was predominantly African American).

None of the congregations have an active health ministry. Despite this fact, all of the churches already support the health of its members in other ways. All of the respondents said that they believed that there is

a connection between physical, emotional and spiritual health and these same respondents "felt it was the role of religious institutions in helping its congregations be physically healthy." The clergy also stated that the main reasons they did not have a health ministry is because of a lack of time, finances and partnerships. This is an indication that if a congregational health program were available and affordable, it would be utilized. And, the pastor's were open to community partnerships to make that happen.

The health barriers faced by the congregations include: cultural, socioeconomic, social environment, and a variety of others (e.g., disabilities, domestic violence, mental illness, lack of healthy foods/affordable and healthy food choices, and lack of access to physical activities). And, among the top health concerns of these pastors are: cancer, aging, and heart disease. These concerns are consistent with the major causes of death in Virginia[6].

A total of 30 satisfactory responses were received from all sectors of the community (civic, clergy, education, government, and medical). Different organizations from each sector expressed an interest in assisting local congregations and faith-based organizations. In addition, many were interested in developing partnerships with the same as long as the need is indicated and identified. However, there is a concern of violating separation of church and state laws.

As a result of this pilot survey, CHR recommends developing 1) a model health ministry program at a state-wide level, 2) a health ministry toolkit/manual, 3) a church member survey, and 4) a pilot model rural health ministry program for congregations, as well as continuing future research, and 5) Educate the public about the laws that are in place between the church and state. Engaging the faith community in these recommendations is essential to program success.

CHR also recommends the following to produce an increase response to future surveys: 1) convene a town hall meeting once key leaders are identified, 2) develop focus groups based on the community sector, 3) offer incentives to complete the survey, 4) identify successful and active health ministries in local congregations to mentor or partner with other churches, 5) develop a model health ministry program at a statewide level 6) develop a health ministry toolkit/manual, 7) develop an individual church member survey, 8) develop a model rural health ministry program, and 9) continue future research.

---

[1]Religious Congregations and Membership in the United States, 2000. Collected by the Association of Statisticians of American Religious Bodies (ASARB) and distributed by the Association of Religion Data Archives (www.theARDA.com) http://www.thearda.com/mapsReports/reports/state/51_2000.asp (*Congregational "adherents" include all full members, their children, and others who regularly attend services. The historically African American denominations are not included in the 2000 congregation and membership totals. Many are also missing in 1990 and most historically African American denominations are missing in the 1980 reports.)

[2]Health and Welfare Ministries, General Board of Global Ministries, The United Methodist Church, New York, New York.

[3]US Census Bureau, 2008 Population Estimates for Virginia. http://factfinder.census.gov/servlet/QTTable?_bm=y&-context=qt&-qr_name=PEP_2008_EST_DP1&-ds_name=PEP_2008_EST&-CONTEXT=qt&-tree_id=808&-redoLog=true&-_caller=geoselect&-geo_id=04000US51&-geo_id=05000US51017&-search_results=01000US&-format=&-_lang=en and http://quickfacts.census.gov/qfd/states/51/51017.html

[4, 5] http://www.city-data.com/county/Bath_County-VA.html

[6]Virginia Department of Health, Office of Minority Health & Public Health Policy, *Virginia Health Equity Report 2008, Executive Summary*

[7]Health and Welfare Ministries, General Board of Global Ministries, The United Methodist Church, New York, New York